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NO.

In The
SUPREME COURT OF THE UNITED STATES

October Term, 1982

HEALTH CARE PLAN OF NEW JERSEY, INC.,
a federally qualified health
maintenance organization,

Petitioner,

vs.

MARGARET M. HECKLER, Secretary
United States Department of Health & Human Services;
J. RICHARD GOLDSTEIN, Commissioner,
New Jersey Department of Health;
New Jersey Hospital Rate Setting Commission,

Respondents,

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PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE
THIRD CIRCUIT

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April 20, 1983

## Question Presented

Whether a state hospital rate law is unlawfully "restrictive" of a health maintenance organization's ("HMO") operating incentives within the meaning of 42 U.S.C. 300e-10 of the Health Maintenance Organization Act of 1973 and the Supremacy Clause where:

(a) The state admits that the rate law has stunted "serious effort at HMO development within the state";

(b) The state admits that the rate law has weakened vital HMO incentives to realize savings of inpatient hospital costs due to shorter lengths of stay;

(c) The rate law has caused federal officials to back down from enforcing federal regulations dealing with HMO cost controls; and

(d) Under the Social Security Act Amendments of 1983, Congress has now directed federal repeal of Medicare waiver of the state rate law because the rate law prohibits HMO-hospital negotiations.

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Stern & Gressman, Supreme Court Practice §41.3 (5th ed. 1978) at 288-289 52, 53

The Petitioner, Health Care Plan of New Jersey, Inc., a federally qualified health maintenance organization, respectfully prays that a writ of certiorari issue to review the judgment order of the United States Court of Appeals for the Third Circuit entered in this proceeding on January 6, 1983.[1/] In a case of first impression, the Third Circuit affirmed--without opinion--the District Court's holding that a state hospital rate law which has the undisputed effect of drastically discouraging the operating structure

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1/ Since the filing of the Complaint in the trial court below, the named state and federal officials have left office. Accordingly, the present occupants of the state and federal offices are indicated in the caption of the case before the Court. The Petitioner corporation has no parent companies, subsidiaries, or affiliates.

and incentives of federally qualified health maintenance organizations (HMOs) is not partially preempted by the Health Maintenance Organization Act of 1973, as amended, 42 U.S.C. §§300e-300e-17, and the National Health Planning Resources and Development Act, as amended, §§300k-300n.

## Opinions Below

The Judgment Order of the Court of Appeals, not yet recorded, appears in the Appendix hereto, along with the denial of Petitioner's petition for rehearing and suggestion for rehearing in banc. The opinion of the District Court for the District of New Jersey is reported at 553 F. Supp. 440 (D.N.J. 1982) and, also, appears in the Appendix.

## Jurisdiction

The judgment of the Court of Appeals

for the Third Circuit was entered on January 6, 1983. A timely petition for rehearing in banc was denied on January 31, 1983, and this petition for certiorari was filed within 90 days of that date. This Court's jurisdiction is invoked under 28 U.S.C. §1254(1).

## Constitutional, Statutory and Regulatory Provisions Involved

- United States Constitution Article VI, cl. 2:

"This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; ...shall be the supreme Law of the Land; ..."

- 42 U.S.C. §300e-10;[2/]
- 42 U.S.C. §300e-11;

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2/ Pursuant to Rule 21(f) the remaining provisions are lengthy. Accordingly, citation alone is given with the pertinent text included in the Appendix hereto beginning at App. 38.

- 42 U.S.C. §300k(a)(4);
- 42 U.S.C. §300k-2(a)(3);
- 42 U.S.C. §300n-1(c)(8);
- 42 U.S.C. §1395b-1(b);
- 47 Fed. Reg. 44612, 44614 (October 8, 1983);
- N.J. Stat. Ann. 26:2H-18(b).

## Statement of the Case

A dispute arose between the petitioner, Health Care Plan of New Jersey, Inc. ("HCP"), a federally qualified health maintenance organization and health officials of the State of New Jersey. The dispute concerned the compatibility with the federal statutes of a 1978 state hospital rate law--N.J. Stat. Ann. §26:2H-18(b) (West 1981) and implementing regulations found at N.J.A.C. 8:31B-1.1 et seq.--under which all third party payors for hospital services, including fee-for-service health insurance plans

as well as HMOs,[3/] are required to pay flat fees for diagnostically-specific hospital services based on a hospital's average costs for rendering those services to all payors.

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3/ An HMO is a health care organization that delivers comprehensive health services to voluntarily enrolled members in return for a fixed, prepaid fee which cannot be retroactively adjusted. (Pl. Ex. 1, p. 4). This Court has recently recognized the fundamental distinction between HMOs and other health insurance plans which are of the fee-for-service type. As noted by the Court:

> "An alternative to the fee-for-service type of insurance plan is illustrated by the health maintenance organizationsauthorized under the Health Maintenance Act of 1973, 42 U.S.C. §300e et seq. Under this form of prepaid health plan the consumer pays a fixed periodic fee to a functionally integrated group of doctors in exchange for the group's agreement to provide any medical treatment that the subscriber might need. The economic risk is thus borne by the doctors."

Arizona v. Maricopa County Medical Soc., 102 S. Ct. 2466, 2470, n. 7 (1982).

The petitioner contended that the state hospital rate law so disrupted its fundamental operating incentives as a federally qualified HMO that it should be exempted from the state law and allowed to negotiate rates it would pay for inpatient hospital services directly with contracting hospitals. Thus, the petitioner claimed that the state hospital rate law was partially preempted by the Health Maintenance Organization Act of 1973, as amended, 42 U.S.C. §300e et seq. read in pari materia with other federal statutes.

The State Hospital Rate Law

One of the purposes of New Jersey's hospital rate law was to redress the financial plight of inner-city hospitals which had incurred large costs caring for indigent patients (App. 11). To

that end, the state statute expressly provides for the inclusion of certain financial elements in each hospital's rate structure which had not been recognized under the previous state hospital rate system. These elements include indigency care costs, bad debts and hospital working capital needs. N.J. Stat. Ann. 26:2H-18(d). Another purpose of the state law was to seek limitation of hospital costs (App. 11; R. Vol. 2, 71-72).

The pertinent provisions of the New Jersey statute provide:

> "Rates of payment by hospital service corporations organized under the law of this State for health care services provided by a hospital shall be set by the [New Jersey Hospital Rate Setting Commission]. Payment by all...purchasers of health care services provided by a hospital shall be at reasonable rates as provided in this act. All payment rates shall be equitable for each payor without discrimination

> or individual preference except for quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole."

N.J. Stat. Ann. 26:2H-18 (App. 51).

The respondent Commissioner of the New Jersey Department of Health ("Commissioner"), issued certain administrative regulations to implement the 1978 hospital rate statute. These regulations, found at N.J.A.C. 8:31B-1 et seq., set up a hospital rate system known as the "Diagnostically Related Group Prospective Case-Mix Hospital Reimbursement Regulatory System". The regulatory scheme is more commonly known as "The DRG System" (App. 13). This system establishes 383 different Diagnosis Related Groupings ("DRGs") representing the complete universe of medical classifications of illnesses and surgical procedures for which hospital patients receive treatment. Under the DRG System hospitals

are required to bill a flat charge which depends on how a patient is diagnosed and what surgical procedures are involved (Pl. Ex. 1, p. 31). Thus, once a patient enters the hospital and is diagnosed, his hospital charge is "set in stone". With few exceptions not pertinent to this case, it makes no difference in computing the final charge how long a patient has actually stayed in the hospital.

Development of the DRG System was funded by a federal grant from the Social Security Administration (R. Vol. 2, 73-75; App. 12). From the onset of the DRG System in New Jersey--which began to be phased into operation at New Jersey's 116 hospitals in late 1980--the federal government has been paying DRG rates to New Jersey hospitals for treatment of patients under the Medicare program,

pursuant to a waiver of standard Medicare reimbursement policies, authorized by 42 U.S.C. §1395b-1(b) of the Social Security Act (R. Vol. 2, 85; App. 13). However, federal laws and policies on Medicare waivers for states having DRG programs have undergone rapid changes in recent months. As pointed out in the petitioner's argument before the Court of Appeals, the respondent Secretary of Health and Human Services ("Secretary") established a Statement of Policy on October 8, 1982--after the District Court trial--which requires future state applications for Medicare waiver under 42 U.S.C. §1395b-1(b) pertaining to state DRG laws to "not preclude HMOs from negotiating their own rates" with hospitals. 47 Fed. Reg. 44612 at 44613 (October 8, 1982). The Secretary's rationale for such a regulation is:

> "HMOs offer a competitive alternative to traditional health care providers. Through years of study with various HMO demonstrations we have concluded that health care utilization of HMO enrollees is somewhat different from the population generally. Often this permits HMOs to negotiate individual payment plans with the hospitals furnishing service to enrollees such as monthly per capita payments. Such negotiations may not be consistent with the diagnostic specific payment units. We are currently engaged in several HMO studies which are in various stages of development. We do not wish to impair the effectiveness of established HMOs by precluding their negotiation with hospitals, concerning reimbursement rates. Thus, any Statewide rate setting demonstration proposal should provide that HMOs may negotiate reimbursement rates with hospitals." (Emphasis provided).

47 Fed. Reg. 44612 at 44614 (App. 49). Indeed, to fill the gap for states such as New Jersey and Maryland which had pre-October 1982 federal waivers for DRG programs, Congress just passed legislation which would require these

states--if they wished to continue obtaining federal Medicare waiver for their state DRG programs--to provide an exemption for HMOs from the state DRG program. The President signed this legislation on April 20, 1983, Social Security Act Amendments of 1983, Pub. L. No. 98-21, §601(c), 129 CONG. REC. H. 1749 to 1753 (Daily Ed. March 24, 1983) (97 Stat. to be codified at 42 U.S.C. §1395). Specifically, as explained in the congressional Conference Committee Report:

> "Under present law, the Secretary has authority to establish Medicare demonstration projects. There are currently four Statewide Medicare demonstrations (MD, NJ, NY and MA) and one area-wide (Rochester NY demonstration).
>
> * * *
>
> Under [§601(c)], the Secretary would be prohibited from (1) denying a State application [to have the Secretary pay for Medicare Services according to the State hospital rate law] on the ground that the State's system is based on a payment methodology other than DRGs,

> or (2) requiring that Medicare expenditures under the State's system be less than the expenditures which would have been made under the Federal prospective payment system. It includes the [existing requirements] for approval of a State system and adds a [further] requirement: if the Secretary determines that the State system will not preclude any HMO... from negotiating directly with hospitals with respect to payment for inpatient hospital services.
>
> * * *
>
> [F]or those states [such as Maryland and New Jersey] which currently have a Medicare waiver the Secretary would be required to continue the State program, if and for so long as, the conditions described above are met." (Emphasis provided).

Conference Report (H.R. Rep. 47), 129 CONG. REC. H. 1777, S. 4084 (Daily Ed. March 24, 1983).

Impact of the State Rate Law On HMOs: The State's Admissions

The respondent state Commissioner does not dispute the devastating impact that New Jersey's hospital rate law has had and continues to have on petitioner, and other New Jersey HMOs. Indeed, in

the state respondent's own words:

> "There have been indications of widespread interest in HMO development [in New Jersey] but awareness of the problems that existing HMOs have encountered has probably caused these groups to move cautiously toward any serious effort at HMO development."

(Pl. Ex. 1, p. 36). Again, as admitted by the State respondent:

> "The economic incentives in a well run pre-paid plan place emphasis on out-of-hospital care, leading to fewer admissions and shorter lengths of stay. Placing HMOs in the DRG system weakens their existing incentives. Also impaired is the HMO's ability to negotiate a hospital rate based upon predictable inpatient volumes for participating hospitals."

Status Report on New Jersey Health Maintenance Organizations (HMOs), New Jersey Department of Health (November 1981) cited at the Court of Appeals level in this case in Plaintiff-Appellant's Opening Brief at 41.

The respondent state Commissioner clearly understands why the DRG System--which requires an HMO to pay a flat rate for a particular medical diagnosis without regard to the number of days an HMO enrollee is in a hospital--weakens HMO incentives and has stunted "serious effort at HMO development". As acknowledged by the state respondent:

> "[T]he DRG impact on HMO derives from the inability [of HMOs] to realize savings in hospital costs due to shorter lengths of stay... Overall, the HMOs forecast that the [DRG System] will have a dramatic impact on their hospital costs, and thus, on their continued viability. The hospital rate setting commission may have to consider special interim measures to reflect the unique characteristics of HMOs as payors in order to avoid critical cash flow problems." (Emphasis provided).

(Pl. Ex. 1, p. 31). The record below indicates that, despite the state-admitted need for "special interim measures", no relief whatsoever was afforded the

petitioner or New Jersey's other HMOs in this respect. (R. Vol. 2, 109 to 111; 138-141).

### Impact of the State Law On Petitioner: Additional Evidence

Uncontradicted evidence was submitted by the petitioner that New Jersey's DRG System has jeopardized the financial solvency of the petitioner (R. Vol. 1, 70, 85; Pl. Ex. 2 & 4); exacerbated the petitioner's attempts to adjust to the DRG-led skyrocketing hospital costs due to the 12-month required lag period in adjusting HMO premium rates (R. Vol. 1, 70-71, 77-79, 104-107; Pl. Ex. 2 & 4); destroyed the petitioner's financial incentives to discharge HMO enrollees as soon as possible after entering a hospital (R. Vol. 1, 55-56, 63-64, 82-83, 100, 105-107; Pl. Ex. 2, 3 & 4); imposed wasteful and duplicative pre-

admission testing while altering the petitioner's basic philosophy of delivering efficient and low-intensity health care outside of a hospital (R. Vol. 1, 21-30, 82, 85, 106; Pl. Ex. 2, 3 & 4); and, discouraged petitioner's medical staff's "discharge planning" to get enrollees out of hospitals as soon as possible and into less costly, less resource-intensive health care facilities, such as nursing homes or out-patient facilities (R. Vol. 1, 21-30, 62-62, 67-70, 82, 85, 100, 105-106; Pl. Ex. 3 & 4).

Impact of the State Rate Law
On Other New Jersey HMOs

Uncontradicted evidence was adduced at trial indicating that a majority of New Jersey's nine HMOs[4/] have experienced

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4/ Six of the nine HMOs in New Jersey are federally qualified. The other federally

drastic interferences with their financial and health care delivery incentives similar to the interferences suffered by the petitioner. While the record below is replete with this uncontradicted proof the following evidence is illustrative:

- Testimony by the medical director of HIP of Greater New Jersey, a federally qualified HMO, that its pre-DRG financial incentives to be "prudent purchasers" of hospital resources were eliminated as well

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4/ qualified HMOs operating in New Jersey as of July 1981 were: HIP of New Jersey; Rutgers Community Health Plan; Southshore Health Plan; Crossroads Health Plan; and CoMed. The non-federally qualified HMOs (which nevertheless operate under the same basic organizational structure of comprehensive medical services in exchange for a fixed prepaid annual premium) were: Cumberland Regional Health Plan; Mercer Regional Medical Groups; and Southern Inter-County Medical Association (SIMA). (Pl. Ex. 1, pp. 38-55).

as its financial incentive to "shop around" to reduce average length of hospital stay and thereby reduce HMO costs (R. Vol. 1, 130-131).

- Testimony by the chief operating officer of Cumberland Regional Health Plan that New Jersey's DRG system "totally erodes the [New Jersey] HMOs'...incentive to reduce hospital days. Because we will pay for the days regardless [under the DRG system]". (R. Vol. 2, 47).

- A statement by the executive vice president of Southshore Health Plan that the DRG system was destroying HMO budgeting predictability and destroying Southshore's incentives to control hospital length of stay (Pl. Ex. 7).

- A statement by the executive director of Rutgers Community Health

Plan that his HMO and other New Jersey HMOs were being "punished for their efficiency" and were "subsidizing the less efficient performance of the more traditional modes of medical care delivery". (Pl. Ex. 8).

The State Rate Laws
Interference With Federal Regulations

By a "Corrective Action Plan" (CAP) promulgated by the federal respondent Secretary on June 30, 1980 the petitioner was required to take certain "medical actions". These included:

> "Newly enforced policy of using contracting per diem hospitals, except where use of non-contracting hospitals is absolutely necessary.
>
> Negotiate per diem contracts with three tertiary care hospitals."

(Pl. Ex. 4). This Secretarial CAP was promulgated under the authority of 42 U.S.C. §300e-11 and 42 C.F.R. 110.904

(c)(2). While the petitioner fully complied with these directives, as well as all other aspects of the Secretarial CAP effective February 1981 (Pl. Ex. 4) the Secretary did not restore the petitioner to compliance with federal law for nearly one year thereafter. Indeed, uncontroverted evidence exists that the Secretary's agents did not immediately restore the petitioner to compliance with federal law because of "fear that the [New Jersey DRG System] will not allow [the petitioner] to be... financially viable". (R. Vol. 2, 13-14; Pl. Ex. 4). While petitioner's compliance with federal law was belatedly restored by the Secretary in January 1982, the Secretary never altered her original federal requirement that the petitioner negotiate per diem rates with hospitals. (Pl. Ex. 4). Likewise, the federal

respondent never explained her failure to enforce this regulation in spite of the contrary DRG state law which prohibits the petitioner from negotiating any hospital rates.

As a result of the foregoing problems, the petitioner, Health Care Plan of New Jersey, Inc., as a federally qualified HMO brought the instant action in a federal court in the District of New Jersey. Declaratory and injunctive relief was sought against the state respondents, Commissioner of Health and Hospital Rate Setting Commission, as well as the federal respondent, Secretary of Health and Human Services. Jurisdiction in the trial court was based on 28 U.S.C. §1331. Petitioner sought to enjoin the defendants in the trial court action from continuing to enforce against petitioner--as a

federally qualified HMO--New Jersey's DRG System. Petitioner sought to uphold its federal right to directly negotiate with hospitals with respect to the rate paid for inpatient hospital services rendered to petitioner's approximately 30,000 enrollees.

The District Court rendered judgment in respondents' favor finding no congressional intent to preempt a state DRG law so that petitioner could directly negotiate rates with hospitals.[5/] In a judgment order, the Court of Appeals totally upheld the District Court's holding (App. 1), finding no partial preemption by virtue of the Health Maintenance Organization Act of 1973,

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5/ The District Court also denied petitioner's additional claims which are not pertinent to this appeal.

as amended, 42 U.S.C. §§300e to 300e-17 read in pari materia with the National Health Planning Resources and Development Act, as amended, §§300k to 300n.

## Reasons for Granting the Writ

### I. The Decision Below Has Decided An Important Question Of Federal Law Which Has Not Been, But Should Be, Settled By This Court And Has Decided Such Federal Question In A Way In Conflict With the Applicable Decisions Of This Court.

The decision of the court below, construing the provisions of the Health Maintenance Organization Act of 1973, 42 U.S.C. §300e et seq. as not mandating federal preemption of state hospital rate laws which prevent HMOs from directly negotiating with hospitals for costs to be paid for inpatient services rendered to HMO enrollees, is predicated upon a complete misconception of the basic operating incentives which Congress found inherent in HMOs. 42 U.S.C. §300e

(b), requires a federally qualified HMO to provide "basic health services" and supplemental health services" "without limitation as to time or cost..." (Emphasis provided). HMO provision of "basic health services" is mandatory. 42 U.S.C. §300e(b)(1). These mandatory "basic health services" include:

(A) Physician services (including consultant and referral services by a physician;

(B) Inpatient and outpatient hospital services;

(C) Medically necessary emergency health services;

(D) Short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

(E) Medical treatment and referral services (including referral services to appropriate ancilliary services) for the abuse of or addiction to alcohol and drugs;

(F) Diagnostic laboratory and diagnostic theraputic radiologic services;

(G) Home health services; and

(H) Preventive health services including (i) immunizations, (ii) well-child care from birth, (iii) periodic health evaluation for adults, (iv) voluntary family planning services, (v) infertility services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction." (Emphasis provided). [42 U.S.C. §300e-1(1)].

Moreover, the petitioner--like all federally qualified HMOs--must provide these services, under continuing federal regulation in a prepaid, fixed, prompt, accessible and fiscally sound manner pursuant to a specific organizational format mandated by Congress. 42 U.S.C. §300e(b) & (c).

Thus, at the outset of analysis, it is clear that HMOs operate under unique financial incentives which are fundamentally different from other traditional fee-for-service health insurers who may freely pick and choose health care services which they will offer and may also

freely adjust their subscriber premiums to meet changing financial developments. Moreover, traditional fee-for-service health insurers are not constrained by the onerous organizational format required of federally qualified HMOS. Indeed, in Arizona v. Maricopa County Medical Soc., 102 S. Ct. 2466, 2470, n. 7 (1982), the Court recently recognized the unique financial operating constraints of HMOs:

> "An alternative to the fee-for-service type of insurance plan is illustrated by the health maintenance organizations authorized under the Health Maintenance Organization Act of 1973, 42 U.S.C. §300e et seq. Under this form of prepaid health plan the consumer pays a fixed periodic fee to a functionally integrated group of doctors in exchange for the group's agreement to provide any medical treatment that the subscriber might need. The economic risk is thus borne by the doctors." (Emphasis provided).

Congress--mindful of the unique burdens and risks required of HMOs and equally mindful of historic state antagonism to HMOs--specifically provided for federal preemption of "restrictive state laws and practices" inimical to basic HMO operating needs. 42 U.S.C. §300e-10, captioned "Restrictive State laws and practices" provides in its entirety:

> "Entities operating as health maintenance organizations
>
> (a) In the case of any entity--
>
> (1) which cannot do business as a health maintenance organization in a state in which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise--
>
> (A) requires as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,
>
> (B) requires that physicians constitute all or a percentage of its governing body,

(C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity, or

(D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency, and

(2) for which a grant, contract, loan, or loan guarantee was made under this subchapter or which is a qualified health maintenance organization for purposes of section 300e-9 of this title (relating to employees' health benefits plans),

such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 300e of this title.

Advertising

(b) No State may establish or enforce any law which prevents a health maintenance organization for which a grant, contract, loan, or loan guarantee was made under this subchapter or which is a qualified health maintenance

organization for purposes of section 300e-9 of this title (relating to employees' health benefits plans), from soliciting members through advertising its services, charges, or other non-professional aspects of its operation. This subsection does not authorize any advertising which identifies, refers to, or makes any qualitative judgment concerning, any health professional who provides services for a health maintenance organization.

Digest of State laws, regulations, and practices; legal consultative assistance

(c) The Secretary shall, within 6 months after October 8, 1976, develop a digest of State laws, regulations, and practices pertaining to development, establishment, and operation of health maintenance organizations which shall be updated at least quarterly and relevant sections of which shall be provided to the Governor of each State annually. Such digest shall indicate which State laws, regulations, and practices appear to be inconsistent with the operation of this section. The Secretary shall also insure that appropriate legal consultative assistance is available to the States for the purpose of complying with the provisions of this section."

It is apparent that two specific portions of this section are given prominence by Congress: (1) 42 U.S.C. §300e-10(a) "[state] requirements... that prevent [an entity] from operating as a health maintenance organization in accordance with section 300e of this title ["shall not apply"]; and (2) 42 U.S.C. §300e-10(c), "the Secretary shall...develop [and periodically update] a digest of State laws, regulations, and practices pertaining to development, establishment, and operation of health maintenance organizations which shall... indicate which State laws, regulations and practices appear to be inconsistent with the operation of this section". In light of these broad provisions, the preemptive scope of 42 §300e-10 is manifestly <u>not</u> limited to the five specific types of laws enumerated

therein. As recognized by the District Court opinion:

> "It is clear that section 300e-10 enumerates five types of traditional regulations of which Congress took notice and which it decided would be unduly restrictive of HMOs. Indeed, regulations which fall within these categories have previously been applied to prevent the development of HMOs and other types of group practice. 1973 2 U.S.C. Cong. & Ad. News pp. 3033, 3057-58. Had a system like the DRG system plan been in operation prior to the enactment of the HMO Act, and had the DRG system's impediments to the effective operation of HMOs been brought to the attention of Congress, the court would be able to say that the failure of Congress to include systems such as the one under consideration within section 300e-10, would be dispositive of plaintiff's preemption claim.
> * * *
>
> Neither the DRG plan, however, nor any system of regulation similar to it has been before Congress [as of the date of the District Court's opinion in February 1982] and it is for this reason that the court's inquiry cannot end with section 300e-10. Its list is not exhaustive for the court is required to make an empirical inquiry into the operation of the DRG plan, in order to

> determine whether it has interfered with the effective operation of a federal program." (Emphasis provided).

553 F. Supp. 440 at 445 (D.N.J. 1982) (App. 24 to 26).

The District Court opinion, which was implicitly endorsed by the Court of Appeals Judgment Order, goes on to acknowledge:

> "Of course, this court is required to read a statute of this nature in a manner which allows the objective of the program it creates to be achieved, and in a way which comports with the rapidly changing circumstances of the medical market." (Emphasis provided).

Id., n. In spite of this lip service to the proper manner of construing a federal statute and analyzing that statute's preemptive effect on state law, the District Court totally disregarded the most tangible, the most persuasive, and the clearest evidence that New Jersey's

DRG hospital rate law is, indeed eviscerating basic financial and organizational operating incentives contemplated by federal law while stunting further HMO development within the state. The decisions below completely omit the telling admissions of the respondent state Commissioner in Pl. Ex. 1, which exhibit sets forth in great detail an "empirical" analysis of how the New Jersey DRG program--by failing to allow HMOs the right to negotiate their own inpatient hospital rates with hospitals--interferes with the basic operating provisions contemplated by the Health Maintenance Organization Act of 1973, as amended, 42 U.S.C. §300e et seq.

The basic assumption of the decision below, that the state DRG plan does not factually interfere with the operation of federally qualified HMOs, is thus

not supported by the record. The lower courts failed to acknowledge, let alone discuss, the state's admission that the DRG plan has stunted "serious effort at HMO development within the state". The lower courts failed to acknowledge, let along discuss, the state's further admission that the DRG law weakens vital HMO incentives to realize savings in hospital costs due to shorter length of hospital stays of HMO enrollees.

Under these circumstances of wholesale judicial avoidance of probative state admissions that the New Jersey DRG law is in fact interfering with and substantially restricting the operational incentives of HMOs, it is submitted that the lower court decisions not only contravene the proper mode of preemption inquiry mandated by the decisions of this Court, but also are so inconsistent

in theory as to leave the intent and meaning of the preemption provisions of the Health Maintenance Organization Act of 1973, in a state of abject confusion.

In considering questions under the Supremacy Clause the Court has at different times made use of the following tests in juxtaposing state law with federal law: conflicting; contrary to; occupying the field; repugnance; difference; irreconcilability; inconsistency; violation; curtailment; and interference with federal purposes. In commenting on the use of these various phrases the Court in Hines v. Davidowitz, 312 U.S. 52, 67 (1941) stated:

> "[N]one of these expressions provides an infallible constitutional yardstick. In the final analysis there can be no crystal clear distinctly marked formula. Our primary function is to determine whether, under the circumstances of this particular

> case [the state] law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." (Emphasis provided).

The above-quoted language has been often repeated and, indeed, has become the "constitutional yardstick" in pre-emption cases. Close analysis reveals that the Hines standard is actually a two-pronged test requiring (1) judicial construction of the "full purposes and objectives of Congress" coupled with (2) a full and complete factual inquiry into the impact of the state law on those congressional purposes and objectives. The lower courts in the case at bar rejected both prongs of the Hines mandate.

First, by purposefully shielding the factual inquiry from the glaring light of the state's admissions regarding the harmful impact of the DRG program on

HMOs operating in New Jersey, the lower courts failed to realistically assess the nature of the state program which clearly creates substantial obstacles to effective HMO operations. Second, the courts below further improperly insulated their preemption inquiry by refusing to plumb the depth and dimension of the "full purposes and objectives of Congress" in enacting the Health Maintenance Organization Act of 1973. Specifically, in spite of the petitioner's arguments to the contrary, the District Court and the Court of Appeals:

- Refused to note the language in the Senate Committee Report endorsing the organizational and financial incentives inherent in HMOs which allow "more efficient and economic [health] services" and "that the federal government must play a

lead role in assisting the development of [HMOs]" (1973-2 U.S. Code Cong. & Ad. News 3033);

- Refused to consider the further language in the Senate Committee Report whereby the importance of the preemption section, 300e-10, was emphasized in light of congressional recognition how:

> "[S]tate legal restrictions could seriously impede the development of health maintenance organizations... the intent of this bill is to provide a strong federal commitment to the growth and development of...health maintenance organizations." (Emphasis provided, Id. at 3039);

- Rejected the basic canon of statutory construction endorsed by this Court that "the total corpus of pertinent [statutory] law and the policies that inspired [those] statutes]" must be considered.

Boy's Market, Inc. v. Retail Clerk's Union Local 770, 398 U.S. 235, 250 (1970). Indeed, instead of considering the fact that the same 93rd Congress which had passed the Health Maintenance Organization Act of 1973 (Pub. L. 93-222) also enacted the National Health Planning and Resources Development Act, 42 U.S.C. §300k to 300n-5 (Pub. L. 93-641) ("NHPRDA")[6/] the lower courts found that the petitioner had no "standing" to assert the provisions of the NHPRDA

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6/ The Court has recognized that in pari materia construction is particularly appropriate when construing acts enacted by the same Congress. U.S. v. American Bldg. Maintenance Industries, 422 U.S. 271, 277 (1975).

(App. 33). In taking this narrow approach, the following important provisions of the NHPRDA dealing with HMOs and the type of health services they provide were overlooked by the courts below:

- Congressional concern for a national health policy providing for "incentives for the use of appropriate levels of health care and for the substitution of ambulatory and intermediate health care for inpatient hospital care", 42 U.S.C. §300k(a)(4);

- Congressional direction that HMOs be given "priority consideration in the formulation of national health planning goals and in the development and operation of federal, state and area health planning and resource development programs", 42 U.S.C. §300k-2(a)(3);

- Congressional imprimatur that, in reviewing "proposed health system changes", states shall consider "the special needs and circumstances of health maintenance organizations", 42 U.S.C. §300n-1(c)(8).

Moreover, the lower courts' acquiescence in permitting the state hospital rate law to displace the federal Secretary's contrary regulation, dated June 30, 1980, that petitioner negotiate contracts with hospitals for payment of subscriber's inpatient services (Pl. Ex. 4) undermines the holding in Fidelity Federal Savings and Loan Association v. de la Cuesta, 102 S. Ct. 3014 (1982). In Fidelity the Court, in striking down a state law which sought to prohibit federally chartered savings and loan associations from enforcing mortgage due-on-sales clauses in the face of a federal administrative regulation which permitted the enforcement of the clauses, held:

> Federal regulations have no less preemptive effect then federal statutes. Where Congress has directed an administrator to

> exercise his discretion, his judgments are subject to judicial review only to determine whether he has exceeded his authority or acted arbitrarily.

Fidelity at 3022. Thus, by failing to give preemptive effect to the Secretary's discretionary rule, promulgated under the congressional direction of 42 U.S.C. §300e-11(b)(1)--which on its face was intended to have "future effect" pursuant to 5 U.S.C. §551(4)--the lower courts disobeyed the holding in Fidelity. At the very least, the courts below should have considered the Secretary's prospective June 30, 1980 rule in pari materia with the Health Maintenance Organization Act of 1973 and the NHRPDA.

Finally, the recent passage of the Social Security Amendments of 1983 discussed earlier in the Statement of the Case--which legislation comes after

the Court of Appeals decision in the case at bar--has a significant bearing on the outcome of this case. In deciding the case at bar, the Court must determine the congressional intent regarding the ability of HMOs to negotiate with hospitals for rates paid for inpatient services, notwithstanding a state hospital rate law which would prohibit HMO-hospital negotiations. Indeed, while the decisions below do not expressly rely on the previously granted Secretarial Medicare waiver of New Jersey's DRG system under 42 U.S.C. §1395b-1(b) as a basis for the holding of no preemption under the Health Maintenance Organization Act of 1973, it is clear that the lower courts found this waiver significant. As noted in the District Court decision which was affirmed by the Court of Appeals Judgment

Order:

> "The federal government has been paying DRG rates to New Jersey health care providers for treating of patients under the Medicare program, pursuant to a waiver of standard Medicare reimbursement principles ([R.] Vol. 2, p. 85)." 42 U.S.C. section 1395b-1(b). [App. 13].

However, with the passage of the Social Security Act Amendments of 1983, Congress has unmistakably amplified its intent to allow HMOs to negotiate with hospitals for inpatient rates to be paid for services provided for HMO enrollees, in spite of state hospital rate laws--like New Jersey's DRG law--which require all payors for hospital services to pay DRG rates. While Title VI of the Social Security Act Amendments of 1983 admittedly deals only with Secretarial Medicare waiver, that federal statute must certainly be considered part of "the total corpus of

pertinent [statutory] law and the policies that inspired [those statutes]" in interpreting the preemption section, 300e-10, of the Health Maintenance Organization Act of 1973. Boy's Market, Inc. v. Retail Clerk's Union Local 770, supra, 398 U.S. 235, 250 (1970). Congressional intent is now crystal clear: State hospital rate laws which prevent HMOs from negotiating inpatient service rates with hospitals are "restrictive" under 42 U.S.C. §300e-10 and, therefore, preempted.7/ Up until the recent

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7/ It should be noted that passage of Title VI of the Social Security Act Amendments of 1983 does not moot this appeal. New Jersey could decide to maintain its "all payor" DRG system, choosing not to exempt HMOs. Under such circumstances, Secretarial Medicare waiver would not occur; but the justiciable issue of whether or not the state DRG law was unlawfully "restrictive" under 42 U.S.C. §300e-10 would still remain. Likewise, even if New Jersey presently decides to grant an HMO

imposition of all-payor state DRG systems, HMOs had been free to negotiate directly with hospitals in ways that served to maximize their potential cost-effectiveness and to encourage innovative delivery and reimbursement arrangements. In negotiating with hospitals, HMOs can take advantage of the volume of predictable business they can bring to the institutions; prompt payment terms; reduction in bad debts resulting from

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7/ exemption to its hospital rate law, in order to qualify for federal Secretarial Medicare waiver under 42 U.S.C. §1395b-1(b), a case or controversey under 42 U.S.C. 300e-10 would continue to exist. Significantly, without judicial resolution of the preemption question under 42 U.S.C. 300e-10, even if New Jersey decides at this time to grant HMO exemption for Medicare waiver purposes, it could change that decision *in futuro*, and merely risk a recision of the Secretarial waiver.

comprehensiveness of coverage and guarantee of eligibility; and the benefit of progressive HMO efforts to reduce stays and contain costs such as pre-admission diagnostic testing and early discharge programs.

HMOs (those that do not own their own hospitals) have employed various methods to reimburse participating hospitals, depending in part on the above factors. They may pay itemized charges or discounted charges; more typically, they pay a more predictable and cost-based all-inclusive per diem rate. Some HMOs contract with hospitals to pay for a given number of beds, whether fully utilized or not, providing the institution with guaranteed "occupancy" in consideration for a preferred rate. Still other HMOs reimburse hospitals on a capitation basis, providing

greater predictability of costs to the HMO and revenues to the hospital.

Regardless of the specific contractual arrangements, HMOs and hospitals have traditionally cooperated in efforts to share services and optimize the utilization of resources. These can include arrangements to facilitate appropriate treatment of patients who present themselves in emergency rooms; hospitals' agreements to accept the HMOs' pre-admission testing, utilization review and early discharge programs; and sharing of costly diagnostic and treatment services.

In summary, HMOs remain a singular model of innovation and reform in an otherwise cost-reimbursement-oriented health care system. In an industry notably lacking the benefits of a competitive market, with disincentives

for consumers, payors or providers to be concerned about cost-effectiveness, HMOs and hospitals have employed considerable creativity in developing financing and delivery arrangements that can benefit the respective institutions, their patients, and the health care system overall. In developing new cost-containment initiatives it is imperative that the design of one such measure by the states does not result in the subversion of another endorsed by the federal government. In the case of the HMO, reliance on its underlying global prospective financing base which has worked so well should take precedence over state efforts to tamper with any of its individual parts. State limitation of HMOs' ability to negotiate directly with hospitals would greatly undermine the HMOs' integrated

financing and delivery structure, endorsed by federal legislation, and choke off future innovative delivery and reimbursement arrangements.

Since the instant dispute involves a case of first impression with obvious ramifications on other federally qualified HMOs' continued ability to challenge "restrictive state laws and practices", and since the decisions below present the prospect of serious hinderance to the effective administration of the Health Maintenance Organization Act of 1973, the Court should grant certiorari. Musicians Federation v. Wittstein, 379 U.S. 171, 175 (1964) (certiorari granted because the question presented was an important one of first impression under the statute); Rothesies v. Electric Battery Co., 329 U.S. 296, 299 (1946) (certiorari granted because

the lower court decisions presented a serious hinderance to the effective administration of the statute); and United States v. Ruzicka, 329 U.S. 287 (1946) (certiorari granted because of the significance of the issue in the administration of the statute). See generally, Stern & Gressman, Supreme Court Practice §4.13 (5th ed.1978) at 288-289.

II. Millions Of Individuals, Thousands Of Hospitals And Hundreds of HMOs Nationwide Are Affected By The Erroneous Statutory Interpretation Of The Courts Below.

The importance of the case at bar is underscored and the logic of granting the writ of certiorari bolstered by the fact that many individuals and institutions are involved or will be affected by the erroneous statutory interpretation below. See generally, Patterson v. Lamb, 329 U.S. 539 (1947), Steelworkers v. Usery, 429

U.S. 305, 307, n. 3 (1977). See also, Stern & Gressman, supra, §4.13 at 289.

The American HMO industry consists of 243 HMOs with a membership nationwide of 10.3 million individuals. These HMOs exist in 40 states and the District of Columbia, charging an average monthly family premium of $132.00. Investors Guide to Health Maintenance Organizations, U.S. Dept. of Health & Human Services (March 1982) at 10.

The petitioner herein has a current enrollment exceeding 30,000 individuals with potential retroactive claims against the DRG System exceeding $500,000.00 (Pl. Ex. 2).[8/] Currently, the petitioner

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8/ This figure is based on estimated retroactive payments which would be due from the petitioner's contracting hospitals pursuant to its original contracts which were abrogated by the DRG system.

is the 58th largest HMO in the nation in terms of enrollment; the petitioner ranks in the top 25% of all HMO nationwide. Investors Guide to Health Maintenance Organizations, supra, at 12-15. Rutgers Community Health Plan--which presented evidence corroborating petitioner's claim in the trial below (Pl. Ex. 8)--is the nation's 37th largest HMO with an enrollment of 41,898 individuals as of June 1982. Id; Status Report on New Jersey Health Maintenance Organizations (HMOs), New Jersey State Department of Health (November 1982) at 13. As of June 1982, New Jersey had 164,805 HMO subscribers spread out over nine HMOs. Status Report on New Jersey Health Maintenance Organizations (HMOs), supra, at 14.

All HMOs in the nation will be affected by the precedent established in the case at bar: it involves the first judicial construction of the meaning of section 300e-10, the "restrictive state laws" provision of the Health Maintenance Organization Act of 1973, 42 U.S.C. §300e et seq. Moreover, the nation's 5,851 community hospitals[9/]--including New Jersey's 116 hospitals--will, likewise, be affected by the court's determination of whether or not HMOs will be able to negotiate with hospitals for in-patient services performed for HMO enrollees, notwithstanding contrary state hospital rate laws.

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9/ Health United States 1980, U.S. Dept. Health & Human Services at 88.

## CONCLUSION

For the foregoing reasons it is respectfully submitted that this petition for a writ of certiorari should be granted.

Respectfully submitted,

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# A P P E N D I X

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 82-5259

HEALTH CARE PLAN OF NEW JERSEY, INC.,
a Federally Qualified
Health Maintenance Organization

v.

RICHARD S. SCHWEIKER, Secretary, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; JOANNE E. FINLEY, Commissioner, NEW JERSEY DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSIONER

Health Care Plan of New Jersey, Inc.,
Appellant

Appeal from the United States District Court for the District of New Jersey - Camden (D.C. Civil Action No. 81-1887)

Argued December 13, 1982

Before HUNTER, GARTH, Circuit Judges, and WEBER,* District Judge

JUDGMENT ORDER
Entered January 6, 1983

* Honorable Gerald J. Weber, United States District Judge for the Western District of Pennsylvania, sitting by designation.

After consideration of all contentions raised by appellant, namely, that New Jersey's hospital rate regulations, N.J.A.C. 8:31B-1.1 et seq., as applied to appellant, are pre-empted by the Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e - 300e-17 (1976 & Supp. IV 1980) and the National Health Planning Resources and Development Act, 42 U.S.C. §§ 300k - 300n (1976 & Supp. LV 1980), it is

ADJUDGED AND ORDERED that the judgment of the district court, ___F. Supp.___(D.N. J. 1982), be and is hereby affirmed.

Costs taxed against appellant.

By the Court

JAMES HUNTER, III,
Circuit Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

| | |
|---|---|
| HEALTH CARE PLAN OF NEW JERSEY, INC., Plaintiff, | Entered February 8, 1982 |
| v. | Civil Action No. 81-1887 |
| RICHARD S. SCHWEIKER, Secretary, United States Department of Health and Human Services; JOANNE E. FINLEY, Commissioner, New Jersey Department of Health; NEW JERSEY RATE SETTING COMMISSION, Defendants. | FINDINGS OF FACT and CONCLUSIONS OF LAW |

BROTMAN, District Judge

This is an action in which plaintiff Health Care Plan of New Jersey, Inc. (hereinafter, "HCP") questions the constitutionality of the application to it of regulations propounded by the New Jersey Department of Health. HCP seeks to enjoin the defendants from continuing to enforce against HCP a state regulatory

system which sets reimbursement rates for hospital services. The system is known as the "Diagnostically Related Group Prospective Case-Mix Hospital Reimbursement Regulatory System" (hereinafter, "the DRG system" or "the DRG plan"). The regulations implementing the DRG system are found at N.J.A.C. 8:31B-1, et seq. HCP claims that the DRG system is invalid as it pertains to hospital rates payable to HCP on the ground that it conflicts with the federal Health Maintenance Organization Act of 1973, as amended, 42 U.S.C. sections 300e through 300e-14, and the National Health Planning Resources and Development Act, 42 U.S.C. sections 300k through 300t, and the system thereby violates the Supremacy Clause. U.S. Const., Art. VI, sec. 2. Plaintiff also alleges that the application of the DRG system

violates HCP's constitutional rights as guaranteed by the Due Process and Equal Protection Clauses of the Fourteenth Amendment, as well as HCP's rights under the Contract Clause. U.S. Const., Amend. XIV and Art. I, sec. 10. This court has jurisdication under 28 U.S.C. section 1331.

Plaintiff seeks declaratory and injunctive relief against the defendants Finley, the New Jersey Department of Health, and the New Jersey Hospital Rate Setting Commission. Plaintiff also seeks to enjoin defendant Schweiker from his alleged failure to prevent the operation of the DRG system insofar as it impairs HCP's ability to meet its obligations under the Health Maintenance Organization Act, supra, and insofar as it interferes with any federal programs which are designed to promote the

financial success of HCP and other health maintenance organizations.

A two day hearing on plaintiff's application for preliminary injunctive relief was held. Following that, additional evidence was submitted and plaintiff's motion for consolidation of the trial on the merits with the first hearing was granted. Fed. R. Civ. P., Rule 65(a)(2). Accordingly, the court hereby enters these findings of fact and conclusions of law.

## FINDINGS OF FACT

1. Plaintiff Health Care Plan of New Jersey, Inc., is a non-profit corporation organized and operating as a health maintenance organization under the New Jersey Health Maintenance Organization Act. L. 1973, c. 337; N.J.S.A. 26:2J-1, et seq.

2. Defendant Richard S. Schweiker, Secretary of the Department of Health and Human Services, is responsible for administering portions of the Health Maintenance Organization Act of 1973, as amended, 42 U.S.C. sections 300e through 300e-14, and the National Health Planning Resources and Development Act of 1974, 42 U.S.C. sections 300k through 300t.

3. Defendants Joanne E. Finley, Commissioner of Health, the New Jersey Department of Health, and the New Jersey Hospital Rate Setting Commission, are state officials or agencies of New Jersey in charge of administering the DRG system under the authority of L. 1971, c. 136, sec. 18; N.J.S.A. 26:2H-18; as amended, L. 1978, c. 83, sec. 10, and under the authority of N.J.A.C. 8:31B-1, et seq.

4.(a) There are nine health maintenance organizations (hereinafter "HMOs") operating in the state of New Jersey under the provision of New Jersey's Health Maintenance Organization Act, supra. Some of these HMOs, including HCP, are "federally qualified HMOs" within the meaning of 42 U.S.C. sections 300e(a) and 300e-5. (Plaintiff's Ex. 1, pp. 3-4.) Federal qualification allows an HMO to receive federal grants, loans, loan guarantees and contracts designed to defray the costs of feasibility surveys, 42 U.S.C. section 300e-2, planning and development, 42 U.S.C. section 300e-3, and initial operations. 42 U.S.C. sec. 300e-4.

4(b). Before becoming federally qualified, an HMO must satisfy the Secretary of Health and Human Services that there exist or are anticipated adequate sources

of revenue to support the services to be provided by the HMO. 42 U.S.C. section 300e-5(b)(3)(G). The HMO must also show that there exist or are anticipated "financial arrangements and capabilities" of the HMO. 42 U.S.C. section 300e-5(b)(3)(I). In order to become federally qualified, an HMO is required to provide a number of "basic health services," including "inpatient and outpatient hospital services." 42 U.S.C. section 300e-1 (1)(b).

5. On June 1, 1976, HCP became a federally qualified HMO. (Cert. of C. Frederick Berger, para. 5). Since that date, HCP has received $1,605,557.00 in grants and $3,154,000.00 in loans from the Department of Health and Human Services. (Vol. 2, pp. 4-6). HCP is in debt to the federal government in

the amount of approximately three million dollars. (Vol. 2, p. 6).

6. HCP became ineligible for additional federal loans in May, 1981, because an HMO may only be assisted during the first sixty months following its federal qualification. (Vol. 1, pp. 79-80; vol. 2, p. 6). 42 U.S.C. section 300e-4(a)(1).

7. Prior to the implementation of the DRG system, HCP had negotiated contracts with three hospitals whereby it paid the hospitals a per diem rate for services rendered by the hospitals for the care of HCP's subscribers. The three affiliated hospitals are Burlington County Hospital, Cooper Medical Center and Our Lady of Lourdes Hospital. From October, 1980, to May, 1981, 54 per cent of the days spent by HCP subscribers in hospitals were in Burlington County Hospital, 31 per cent in Cooper Medical Center, 5 per cent in Our Lady of Lourdes Hospital, and the rest in non-contracting

hospitals. (Vol. 1, pp. 21, 30 54).

8(a). In 1978, the New Jersey Legislature passed L. 1978, c. 83, amending the Health Care Facilities Planning Act, N.J.S.A. 26:2H-1, et seq., and providing for the establishment of a comprehensive system of regulatory control over hospital rates. One of the purposes of this law was to redress the financial plight of inner-city hospitals which had incurred large costs caring for indigent patients. To that end the statute expressly provided for the inclusion of certain financial elements in the hospital rate structure which had not been recognized under the previous rate review system. These elements included indigency care costs, bad debts and working capital needs. N.J.S.A. 26:2H-18(d). Another purpose of the law was to permit effective limitation of hospital costs. (Vol. 2, pp. 71-72).

8(b). The 1978 New Jersey statute provides that all payment rates "shall be equitable for each payor or class of payors without discrimination or individual preference...." The statute permits the Hospital Rate Setting Commission to grant differentials in the payment rates to a payor or class of payors for "quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole." N.J.S.A. 26:2H-18(b).

9. The New Jersey Department of Health propounded N.J.A.C. 8:31B-1, et seq., which implements the 1978 statute and which embodies the DRG system. This system establishes 383 Diagnosis Related Groupings, representing medical classifications of illnesses for which hospital patients are treated. Development of the DRG system was funded by a

federal grant from the Social Security Administration. (Vol. 2, pp. 73-75). The federal government has been paying DRG rates to New Jersey health care providers for treatment of patients under the Medicare program, pursuant to a waiver of standard Medicare reimbursement principles. (Vol. 2, p. 85). 42 U.S.C. section 1395-1(b).

10. Normally, a hospital under the DRG system is required to bill in accordance with the nature of the patient's illness. Each patient is assigned to one of the 383 Diagnostic Related Groupings through the use of medically accepted techniques of diagnosis. The DRG system establishes upper and lower "trim points"--expressed as numbers of days--for each illness. These trim points represent normative bounds within which a patient assigned to a particular one of the 383 illnesses

may be expected to remain in the hospital. If a patient remains in the hospital beyond the upper trim points, the hospital may bill for actual services rendered. Likewise, if a patient leaves before the period expressed by the lower trim point begins, the patient is charged for actual services. In most cases, however, the diagnosis assigned to a patient establishes the amount which may be paid to the hospital.

11. The application of the DRG system is being carried out over a period of years. Burlington County Hospital began to be governed by the DRG system in May, 1981. (Vol. 1, p. 22).

12. Physicians on the staff of HCP make efforts to keep HCP subscribers out of hospitals by delivery of preventive health care and education. (Vol. 1, p. 22).

13. Pre-admission testing is done by HCP personnel outside of hospitals. (Vol. 1, p. 22).

14. Efforts are made by HCP physicians to have subscribers who are in hospitals discharged therefrom as early as possible. (Vol. 1, p. 23).

15. HCP's main source of income is from subscriber premiums, which are established annually by contract between HCP and each subscriber. These premiums cannot be changed more often than once each year. (Vol. 1, pp. 24-25).

16. The imposition of the DRG system results in duplication of pre-admission testing where such testing results in a decision to hospitalize. Hospitals are required to engage in extensive testing in order to complete a diagnosis. To this extent, the DRG system makes pre-admission testing outside of hospitals wasteful and duplicative of testing

performed at hospitals. (Vol. 2, pp. 38-39, 85). Pre-admission testing does, however, produce benefits for HCP in that it reduces the number of hospital stays for its subscribers, thus reducing HCP's expenses (Vol. 1, p. 31) and gives HCP the ability to verify or to dispute diagnoses made by hospitals, which form the bases for the hospitals' billing of HCP. (Vol. 1, pp. 45, 66).

17. The DRG system reduces fiscal incentives for HCP physicians to influence hospitals to discharge HCP subscribers as rapidly as possible once the subscribers in question have stayed in the hospital beyond the time established by the lower trim points of the illnesses assigned to the patients. (Vol. 1, p. 27). The DRG system does, however, provide an inducement for a hospital to reduce

each patient's length of stay. (Vol. 2, pp. 63-64; Vol. 2, p. 87). Further, every physician has an ethical obligation to attempt to reduce each patient's length of stay. (Vo. 1, p. 32).

18. The imposition of the DRG system has caused HCP to pay more to Burlington County Hospital than it would have paid under its per diem contract. (Vol. 1, pp. 70-77). Plaintiff expected its hospital costs to rise 20% as a result of the DRG system, and this expectation was reflected in rates charged to subscribers beginning in January, 1981. (Vol. 1, pp. 102-105). Hospital costs to HCP rose at an annual rate of 30% during the first month of the DRG system at Burlington County Hospital, (Vol. 1, p. 75) and continued to rise at approximately the same rate during the second month. (Docket Entry #11).

As a result of this misforecast of the amount that costs to HCP would rise due to the imposition of the DRG system, HCP has suffered financial reverses. (Vol. 1, pp. 92-96).

19. The assignment of a Diagnostic Related Grouping to each patient is subject to some degree of manipulation, and a hospital has an incentive to assign to each patient an illness which will result in the greatest amount of revenue for the hospital. (Vol. 1, pp. 65-66; Vol. 2, pp. 84-85, 123-24). Much of this manipulation would, however, be illegal, fraudulent and unethical. (Vol. 2, pp. 34-35). Any such manipulation may be monitored when patients have undergone pre-admission testing. (See para. 16, ante).

20. In April, 1980, the Secretary of Health and Human Services determined

that HCP was not meeting the fiscal requirements to allow it to remain a federally qualified HMO. In order to remedy this, HCP was required to make efforts to negotiate per diem contracts with three hospitals and to make efforts to see that as many of HCP's subscribers as possible were treated under these contracts when hospitalization was required. HCP later became a fiscally sound operation within the meaning of the Health Maintenance Organization Act of 1973, and began to repay its loans to the federal government. HCP sought to be declared in compliance with federal directives in February, 1981, but has not been declared in compliance. HCP has been told informally that it would not be declared in compliance because of the financial reverses it has suffered since the imposition of

the DRG system. (Plaintiff's Exhibit 4, and exhibits attached thereto; Volume 1, pp. 79-81; Vol. 2, pp. 7-15). Failure to be declared in compliance with the Secretary's directives has itself compounded the financial difficulties faced by HCP, in part because without compliance, HCP loses statutory right to have membership in HCP offered to employees of many large private and public employers. 42 U.S.C. section 300e-11(b)(1).

21. Plaintiff has applied to the Hospital Rate Setting Commission for permission to pay a lower rate than other payors, but has failed to satisfy the Commission that it is entitled to the relief it seeks. Except for showing that HCP subscribers require fewer hospital services during a maternity stay than other

patients, HCP failed to show that its subscribers required fewer hospital services during their stays than did other patients for any other Diagnostic Related Grouping. (State Defendant's Exhibit 2).

## CONCLUSIONS OF LAW

Plaintiff argues that the application of the DRG plan to it is preempted by federal law because the plan interferes with HCP's ability to operate effectively as an HMO. Our starting point must be 42 U.S.C. section 300e-10, which is an enumeration of certain kinds of state laws which are rendered inoperative as against HMOs. This section, as amended in 1976, also sets forth certain duties of the Secretary of Health and Human Services which must be carried

out with an eye towards preventing the enforcement of such state laws against HMOs. The section in its entirety reads as follows:

> (a) In the case of an entity--
>
> (1) which cannot do business as a health maintenance organization in a State in which it proposes to furnish basic and supplemental health services because that State by law, regulation or otherwise--
>
> (A) requires as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,
>
> (B) requires that physicians constitute all or a percentage of its governing body,
>
> (C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity, or
>
> (D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against involvency, and

(2) for which a grant, contract, loan or loan guarantee was made under this subchapter or which is a qualified health maintenance organization for purposes of section 300e-9 of this title (relating to employees' health benefits plan),

such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 300e of this title.

(b) No State may establish or enforce any law which prevents a health maintenance organization for which a grant, contract, loan, or loan guarantee was made under this subchapter or which is a qualified health maintenance organization for purposes of section 300e-9 of this title (relating to employees' health benefits plans), from soliciting members through advertising its services, charges, or other nonprofessional aspects of its operation. This subsection does not authorize any advertising which identifies, refers to, or makes any qualitative judgment concerning, any health professional who provides services for a health maintenance organization.

> (c) The Secretary shall, within 6 months after October 8, 1976, develop a digest of State laws, regulations, and practices pertaining to development, establishment, and operation of health maintenance organizations which shall be updated at least quarterly and relevant sections of which shall be provided to the Governor of each State annually. Such digest shall indicate which State laws, regulations, and practices appear to be inconsistent with the operation of this section. The Secretary shall also insure that appropriate legal consultative assistance is available to the States for the purpose of complying with the provisions of this section.

It is clear that section 300e-10 enumerates five types of traditional regulations of which Congress took notice, and which it decided would be unduly restrictive on HMOs. Indeed, regulations which fall within these three categories have previously been applied to prevent the development of HMOs and other types of group practice. [1973] 2 U.S.C. Cong. & Ad. News pp. 3057-58. Had a system like the DRG plan been in operation prior to

the enactment of the HMO Act, and had the DRG system's impediments to the effective operation of HMOs been brought to the attention of Congress, the court would be able to say that the failure of Congress to include systems such as the one under consideration within section 300e-10 would be dispositive of plaintiff's preemption claim. See DeVeau v. Braisted, 363 U.S. 144, 151, 153-54 (1960).

Neither the DRG plan, however, nor any system of regulation similar to it has been before Congress, and it is for this reason that the court's inquiry cannot end with section 300e-10. Its list is not exhaustive* for the court

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* Of course, this court is required to read a statute of this nature in a manner which allows the objective of the program it creates to be achieved, and in a way

is required to make an empirical inquiry into the operation of the DRG plan, in order to determine whether it has interfered with the effective operation of a federal program. This method of inquiry, advocated by plaintiff in this action,

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which comports with the rapidly changing circumstances of the medical market. Jerome Frank, Words and Music: Some Remarks on Statutory Interpretation, 47 Colum. L. Rev. 1259 (1947). In another era, Justice Holmes stated:

> We recognize that courts have been disinclined to extend statutes modifying the common law beyond the direct operation of the words used, and that at times this disinclination has been carried very far. But it seems to us that there may be statutes that need a different treatment. A statute may indicate or require as its justification a change in the policy of the law, although it expresses that change only in the specific case most likely to occur to the mind. The Legislature has the power to decide what the policy of the law shall be, and if it has intimated its will, however, indirectly that will should be recognized and

was employed by the Supreme Court in Nash v. Florida Industrial Commission, 389 U.S. 235 (1967), and in City of Burbank v. Lockheed Air Terminal, 411 U.S. 624 (1973). See also Hines v. Davidowitz, 312 U.S. 52 (1941).

Where preemption is the issue, "each case turns on the peculiarities and features of the federal regulatory scheme in question." City of Burbank v. Lockheed Air Terminal, supra, 411 U.S. at 638, citing Hines v. Davidowitz, supra, and Portland Cement Co. v. Detroit, 362 U.S. 440 (1960). It has already been

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> obeyed. The major premise of the conclusion expressed in a statute, the change of policy that induces the enactment, may not be set out in terms, but it is not an adequate discharge of duty for courts to say: We see what you are driving at, but you have not said it and therefore we shall go on as before.

Johnson v. United States, 163 F. 30, 32 (1908).

explained, ante, that Congress has established a category of federally qualified HMOs, of which HCP is one. As such, HCP is availed of certain provisions of federal law which enable it to market its services in the form of employee benefit plans. It cannot be doubted that Congress determined that the profusion and maintenance of federally qualified HMOs would enhance the nation's opportunities for decent health care at a reasonable price.

Further, federal qualification makes an HMO a recipient of large amounts of federal monetary aid, most of which is in the form of loans and loan guarantees. The court assumes that it was intended that these loans were granted with the expectation of repayment, and that state laws which are a direct impediment to repayment act to frustrate Congressional goals.

These two factors--the grant of the imprimatur of federal qualification and the giving of monies--do not state the full measure of federal involvement with HCP. Plaintiff had made a commitment to the Secretary whereby it promised that it would entere into per diem contracts with its affiliated hospitals, and that it would make an effort to use those hospitals as much as possible. It was thought that these per diem contracts would increase the ability of plaintiff to repay its loans and to provide services to its subscribers.

It is on this mandate to enter ino per diem contracts that plaintiff's pre-emption argument turns, for the DRG system makes such contracts illegal. It has not been shown, however, that per diem contracts are an essential prerequisite to HCP's profitability. Profitability and the

provision of services to subscribers are the two keys to federal qualification; the per diem method of contracting for those services is the means to those ends, but is not itself the goal of the federal program. The court finds that better financial planning would have prevented HCP's present financial straits, and it is inferred that it is HCP's current deficit which prevents it from being declared in compliance, rather than the illegality per se of per diem contracts.

Plaintiff contends that the existence of per diem contracts has been the reason why HCP has kept its costs down and the reason why the public would be induced to enroll as members of HCP. The per diem contracts, therefore, have been the reason why HCP has kept its costs down and the reason why the public would be induced to enroll as members of HCP.

The *per diem* contracts, therefore, had given HMOs like HCP a competitive advantage over more traditional sources of medical care, because they had given HCP physicians a financial inducement to reduce the amount of time spent in hospitals by HCP subscribers. Under the DRG system, the advantage derived from the shortening of hospital stays shifts to the hospitals themselves, along with the inducement to do so. Nevertheless, it cannot be said that HCP has thereby lost its entire competitive advantage. By the use of pre-hospitalization testing and by emphasis on preventive care, HMOs remain in a unique position to minimize the costs to its subscribers. Moreover, there is no basis for the assertion that Congress intended to give HMOs a competitive advantage in the medical

marketplace. The act dealing with HMOs contains several provisions which set HMOs on an equal footing with other medical care suppliers, see, 42 U.S.C. sections 300e-10, 300e-11, but there is no provision which is aimed at guaranteeing that they will forever thrive in the competitive marketplace. The Supreme Court has repeatedly stated that state regulation is not to be displaced by a federal program unless "Congress has unmistakably so ordained." Alessi v. Raybestos-Manhattan, Inc., ___U.S. ___, 101 S. Ct. 1895, 1905 (1981). Because Congressional intent to preempt state laws is not to be lightly inferred, e.g., Merill Lynch, Pierce, Fenner & Smith, Inc. v. Ware, 414 U.S. 117, 127 (1973), the court declines to give the expansive reading to the federal statutes which the

plaintiff advocates.

Plaintiff further relies on the National Health Planning & Resources Development Act of 1974, 42 U.S.C. sections 300k through 300t, as an additional source of federal preemption. Plaintiff points especially to 42 U.S.C. section 300k-2, which sets forth a Congressional finding as to seventeen factors which "deserve priority consideration in the formulation of national health planning goals and in the development and operation of federal, state and area health planning and resource development programs." 42 U.S.C. section 300k-2(a). A number of these factors are pertinent to HCP, including the third of the list of seventeen, which specifically mentions HMOs. Plaintiff has not explained why this list gives it standing to call for the invalidation

of the DRG system or of any state law. Nor has plaintiff explained why it is entitled to relief under 42 U.S.C. section 300n-1(c). This subsection, along with 42 U.S.C. section 300n-1(a), deals with factors to be considered when federal funds are given, 42 U.S.C. section 3001-2(e), (g), (referred to in 42 U.S.C. section 300n-1(a)) and when states consult with the federal government. 42 U.S.C. sections 3001-2 (f), 300m-1. If these statutes provide grounds for preventing the use of federal funds in certain cases, it is enough to say that plaintiff has not sought this form of relief. The provisions appear to create no warrant for invalidation of state law.

For these reasons, the court concludes that the DRG plan is not preempted by federal law. Consequently,

the Secretary may not be enjoined to declare that the DRG system is invalid within the meaning of 42 U.S.C. section 300e-10(c). Further, plaintiff has stated in its brief that it wishes to have this court order the Secretary to declare that HCP is in compliance with the provisions of the HMO Act. The court must decline to do so because HCP has not shown that it is in a financial position to repay its loans.*

* * *

For these reasons, the court will enter judgment in favor of the defendants and against the plaintiff.

STANLEY S. BROTMAN
United States District Judge

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* The balance of Judge Brotman's Opinion concerned claims under the Due Process and Equal Protection Clauses of the Fourteenth Amendment, as well as the Contracts Clause. These portions of the Opinion are not relevant to the question raised in the present Petition.

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

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No. 82-5259

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HEALTH CARE PLAN OF NEW JERSEY, INC. a federally qualified health maintenance organization

Plaintiff-Appellant

v.

RICHARD S. SCHWEIKER, Secretary, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; JOANNE E. FINLEY, Commissioner, NEW JERSEY DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSIONER

Defendants-Appellees

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SUR PETITION FOR REHEARING
Entered January 31, 1983

Present SEITZ, Chief Judge, ALDISERT, ADAMS, GIBBONS, HUNTER, WEISS, GARTH, HIGGINBOTHAM, SLOVITER, BECKER, Circuit Judges

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The Petition for Rehearing Filed By

PLAINTIFF-APPELLANT

in the above entitled case having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the

circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court in banc, the petition for rehearing is denied.

By the Court,

JAMES HUNTER, III,
Judge

42 U.S.C. §300e-10.
Restrictive State laws and practices:

Entities operating as
health maintenance organizations

(a) In the case of any entity--

(1) which cannot do business as a health maintenance organization in a state in which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise--

(A) requires as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,

(B) requires that physicians constitute all or a percentage of its governing body,

(C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity, or

(D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency, and

(2) for which a grant, contract, loan, or loan guarantee was made under this subchapter or which is a qualified health maintenance organization for purposes of section 300e-9 of this title (relating to employees' health benefits plans),

such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 300e of this title.

Advertising

(b) No State may establish or enforce any law which prevents a health maintenance organization for which a grant, contract,

loan, or loan guarantee was made under this subchapter or which is a qualified health maintenance organization for purposes of section 300e-9 of this title (relating to employees' health benefits plans), from soliciting members through advertising its services, charges, or other nonprofessional aspects of its operation. This subsection does not authorize any advertising which identifies, refers to, or makes any qualitative judgment concerning, any health professional who provides services for a health maintenance organization.

Digest of State laws, regulations, and practices; legal consultative assistance

(c) The Secretary shall, within 6 months after October 8, 1976, develop a digest of State laws, regulations, and practices pertaining to development, establishment and operation of health maintenance organizations which shall be updated

at least quarterly and relevant sections of which shall be provided to the Governor of each State annually. Such digest shall indicate which State laws, regulations, and practices appear to be inconsistent with the operation of this section. The Secretary shall also insure that appropriate legal consultative assistance is available to the States for the purpose of complying with the provisions of this section.

42 U.S.C. §300e-11.
Continued regulation of health maintenance organizations:

Determination of deficiency

(a) If the Secretary determines that an entity which received a grant, contract, loan, or loan guarantee. .as a health maintenance organization...--

(1) fails to provide basic and supplemental services to its members,

(2) fails to provide such services in the manner prescribed by...this title, or

(3) is not organized or operated in the manner prescribed by...this title,

The Secretary may take the action authorized by subsection (b) of this section.

Action by Secretary upon determination:

(b)(1) If the Secretary makes...a determination described in subsection (a) of this section, the Secretary shall notify the entity in writing of the determination.

Such notice shall specify the manner in which the entity has not complied with such assurances and direct that the entity initiate...such action as may be necessary to bring...the entity into compliance with the assurances.

* * *

(2) If the Secretary makes...a determination described in subsection (a) of this section, the Secretary may...bring a civil action in the United States district court for the district in which such entity is located to enforce its compliance with the assurances it furnished respecting the provision of basic and supplemental health services or its organization or operation, as the case may be, which assurances were made in connection with its application under the subchapter, for the grant, contract, loan, or loan guarantee."

42 U.S.C. §300k(a)(4).
Congressional Findings:

"...The Congress makes the following findings:

* * *

(4) increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care."

42 U.S.C. §300k-2(a)(3)
National health priorities;
strengthening competition
in supply of services:

"...The Congress finds that the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State and area health planning and resources development programs:

* * *

(3) The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care."

42 U.S.C. §300n-1(c)(8).
Procedures and criteria for
review of proposed health
system changes:

* * *

"...Criteria required...for health systems agency, State agency, and Statewide Health Coordinating Council Review shall include consideration of at least the following:

* * *

(8) The special needs and circumstances of health maintenance organizations."

42 U.S.C. §1395b-1(b)
Waiver of certain payment or reimbursement requirements; advice and recommendation of specialists preceding experiment and demonstration projects:

"In the case of any experiment or demonstration project under...this section, the Secretary may waive compliance with the requirements of this subchapter and subchapter XIX of this chapter insofar as such requirements relate to reimbursement or payment on the basis of reasonable cost, or (in the case of physicians) on the basis of reasonable charge, or to reimbursement or payment only for such services or items as may be specified in the experiment; and costs incurred in such experiment or demonstration project in excess of the costs which would otherwise be reimbursed or paid under such subchapters may be reimbursed or paid to the extent that such waiver applies to them (with such excess being

borne by the Secretary). No experiment or demonstration project shall be engaged in or developed under...this section until the Secretary obtains the advice and recommendations of specialists who are competent to evaluate the proposed experiment or demonstration project as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct the proposed experiment or demonstration project, and its relationship to other similar experiments and projects already completed or in process."

47 Fed. Reg. 44612, 44614.
Health Care Financing Administration,
Medicare and Medicade Programs,
Statement of Policy Concerning
Approval of Statewide Hospital
Reimbursement Systems
Demonstration Projects.
Statement of Policy:

"...42 U.S.C. 1395b-1, authorizes the Secretary to conduct demonstration projects for the purpose of determining the effectiveness of health care reimbursement systems established under State law. This notice sets forth the general criteria under which HCFA will ordinarily consider approval of demonstration projects using a statewide hospital reimbursement system.

Date: Effective October 8, 1982.

* * *

...Freedom for Health Maintenance Organization (HMO) to Negotiate Rates. HMOs offer a competitive alternative to traditional health care providers. Through years of study with various HMO demonstrations, we have concluded that health care

utilization of HMO enrollees is somewhat different from the population generally. Often this permits HMOs to negotiate individual payment plans with the hospitals furnishing services to enrollees such as montly per capita payments. Such negotiations may not be consistent with a diagnostic specific payment units. We are currently engaged in several HMO studies which are in various stages of development. We do not wish to impair the validity of these HMO studies or impair the effectiveness of established HMOs by precluding their negotiation with hospitals concerning reimbursement rates. Thus, any Statewide rate setting demonstration proposals should provide that HMOs may negotiate reimbursement rates with hospitals."

N.J.S.A. 26:2H-18(b):

Payment by...purchasers of health care services provided by a hospital shall be at reasonable rates...as provided in this act. All payment rates shall be equitable for each payor or class of payors without discrimination or individual preference except for quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole.